BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MAZEN H. KHAYATA, M.D.** Holder of License No. **20382** For the Practice of Allopathic Medicine In the State of Arizona.	**Board Case No. MD-04-1504A** **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 9, 2006. Mazen H. Khayata, M.D., ("Respondent") appeared before the Board with legal counsel Paul Giancola for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 20382 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-04-1504A after receiving notification of a medical malpractice settlement involving Respondent's care and treatment of an eighty-eight year old female patient ("RB"). RB was admitted to the hospital on June 1, 2001 with multiple medical problems and complaints, including falling. An internist managed RB's care and ordered a brain CT scan. A radiologist erroneously read the CT scan as a left temporal epidural with mass effect. Because this is a life-threatening situation, the internist called for a consultation with Respondent, a neurosurgeon. Respondent saw the radiologist's report and RB, but did not see the CT scan for two hours. Prior to reviewing the CT scan Respondent scheduled surgery and instructed fresh frozen plasma be transfused with IVP. As a result of the scheduled surgery, the internist ordered

fresh frozen plasma administered to RB. The fresh frozen plasma was administered too quickly and RB had preoperative fluid overload and expired.

4. Respondent testified he remembered RB very well and he was on-call the Saturday she was brought to the emergency room and was asked to consult on her because she had CT evidence of an epidural hematoma. Respondent testified he also found out RB was on Coumadin because of congestive heart failure and her prothrombin time ("PT") was elevated in the twenty range. Respondent testified he went to RB's bedside to see her and got her history, including signs of elevated intracranial pressure like headaches, nausea, vomiting, and some drowsiness. Respondent testified on his examination RB was normal and there were no other symptoms. Respondent testified his plan was that RB may need surgery and, of course, first her PT needed to be corrected, but that was ordered by the internist ("Dr. A"). Respondent testified he wanted to go and look at the CT scan to see the epidural hematoma because the reading was that it was in the left temporal fossa and in the setting of RB being on Coumadin it is a bigger step to have a bleed up there. Respondent testified when he went back to RB she had unfortunately already received the six units of fresh frozen plasma ("FFP") and was in fluid overload. Respondent testified he then found out the CT scan was totally normal and cancelled the surgery. Respondent testified RB never recovered.

5. The Board asked Respondent when he first saw RB and did a neurological examination. Respondent testified he went to RB's bedside at approximately 12:15 on June 1, 2001 and got the history that she had been falling, was on Coumadin, and having some nausea, vomiting, headaches, and drowsiness. The Board noted the first order it saw on the medical record was at 22:35 and then at 22:45 it says "low Coumadin." The Board asked Respondent if he saw RB prior to the first order at 22:35 because it is almost ten hours from when he first saw her at 12:15. Respondent corrected his prior answer and testified he first saw RB on June 2, 2001. The Board directed Respondent to the order sheet for June 2, specifically the order for

Zinacef NPO, consent for craniotomy for drainage of left-sided epidural hematoma, and neuro checks. The Board asked if that was Respondent's local order. Respondent testified it was. The Board asked Respondent if he had seen the CT scan when he ordered a consent for craniotomy. Respondent testified he had not and he ordered the consent just in case she needed the craniotomy because he had told her she was in good shape and awake and alert, but had some signs of elevated intracranial pressure, and might need a craniotomy. Respondent testified this was why he wanted to make RB NPO – in case she deteriorated quickly and he had to take her to surgery.

6. The Board asked if Respondent agreed from a review of the record it did not look like RB was in danger of herniating. Respondent agreed. The Board asked Respondent if he thought before he ordered the consent for the craniotomy, since RB was not in any danger, he should keep her NPO and go look at the scan. Respondent testified he saw the scan a few hours later at around 2:30 or 2:45. The Board noted once Respondent wrote the order for the consent for craniotomy for drainage there was a number of orders that began to be written getting RB ready for surgery and one of those orders was Respondent's order for the six units of FFP. The Board directed Respondent to this order and noted the orders that followed included an EKG, chest X-ray, and 10 milligrams of intravenous Vitamin K. The Board asked who wrote the orders that followed Respondent's order for the craniotomy. Respondent testified Dr. A wrote those orders. The Board asked if Respondent spoke with Dr. A after ordering the craniotomy. Respondent testified he did not and Dr. A wrote the orders on her own without checking with him. Respondent testified he wished Dr. A had checked with him because he would have told her how he usually corrects the PT and Coumadin.

7. The Board asked if Respondent was planning to do the craniotomy that day. Respondent testified he would only if RB deteriorated neurologically and her INR had reversed. The Board asked Respondent what he did when he looked at the CT and saw no epidural

hematoma. Respondent testified he just cancelled the surgery, but unfortunately it was two hours later and during that period of time RB had already received six units of FFP and was in failure. The Board directed Respondent to the third paragraph of the cardiology consult that begins "a head CT was obtained." The Board noted the next sentence said "the patient was then taken for planned surgical evacuation. There was some difficulty. The decision was made not to proceed with the temporal craniotomy drainage at that time and the patient was subsequently admitted to the floor. Following transfer back to the floor. . . ." The Board asked where RB had gone – had she gone to the operating room. Respondent testified by the time he saw her she had never left the intensive care unit ("ICU") and was still in the ICU, the preop area, and the preop nurses and the anesthesiologist saw her. The Board asked if RB had gone to the operating room after the ICU because the cardiologist consult says "following transfer back to the floor, the patient had respiratory failure requiring intubation." Respondent testified RB was in the ICU and she essentially stayed there and was seen by the preop nurses and when he told them surgery was cancelled, they left.

8. The Board asked Respondent if he was saying RB had been stable in ICU and was transferred to the floor where she then developed respiratory failure. Respondent testified he was not. The Board asked if it was reading the record correctly. Respondent testified RB was intubated in the ICU that day because of heart failure. The Board again directed Respondent to the record where it said "following transfer back to the floor, the patient had respiratory failure requiring intubation and mechanical inhalation and then was transferred to ICU." The Board noted it did not know what happened to this patient, the cardiologist was recalling what happened and how RB got to the floor and Respondent says she was in ICU. The Board noted it sounded very much like RB was on the way to surgery and was transferred back to the floor from ICU. The Board asked if Respondent could assist with the record. Respondent testified he was pretty sure there were hospital records for every day RB was in ICU. The Board noted it was wondering

where RB went after the consent for surgery was signed – why was she taken out of ICU, transferred to the floor and resuscitated there.

9. The Board looked at the CT scan and noted no shift of the midline structure and no evidence of an intracranial bleed. Respondent testified he saw some streak artifact behind the orbital cuts and maybe that was the reason for the report of the epidural hematoma bleed. The Board directed Respondent to page four of the hospital records where it said "6 to N surg" and asked if that along with "CT left temporal EDH for epidural hematoma" was his note. Respondent testified it was. The Board asked if Respondent had looked at the CT scan when he wrote this note. Respondent testified he had not at that time. The Board noted it could not tell exactly what time the note was written. Respondent testified it was written when he originally saw RB at her bedside at 12:00 p.m. The Board asked if where Respondent wrote "CT left temporal EDH for epidural hematoma" he wrote it was the radiologist's opinion and not his own. Respondent testified he had not. The Board noted the record was saying Respondent diagnosed a "CT left temporal EDH for epidural hematoma," but he had not looked at the CT scan. The Board noted under "impression" Respondent wrote "Left temporal EDH for secondary to falls and will correct the PT. She will need a left temporal craniotomy for drainage." The Board asked if Respondent had seen the CT scan himself when he made this decision and imparted it by the record to other doctors who were handling the case. Respondent testified he had not. The Board asked if he had spoken to the radiologist. Respondent testified he had not.

10. The Board asked Respondent who ordered the FFP. Respondent testified Dr. A gave RB the six units of FFP and, if he is going to correct the PT time with FFP he gives two units of FFP over four hours each and then he gives Lasix IV push to draw it out of her system with each IV. Respondent testified in RB's case she was given the six units of FFP between noontime and two o'clock when he returned to her bedside and RB was also wide open, which is totally unheard of. Respondent testified unfortunately when he saw RB she was already in heart failure

and that is why she needed to be intubated. The Board noted Respondent testified earlier he often takes care of reversing the anticoagulants on patients. Respondent testified he did and he wished he did in RB's case. The Board asked if in this process Respondent measures the patient's bleeding times. Respondent testified he did after every two units because many times he finds out after two units that it is normal and he does not need the whole six units. The Board asked Respondent if he would ever give six units. Respondent testified he has had to give the whole six units, but usually he has done that over three days and each day he gives two units and he corrects the PT. The Board asked if when he corrects the Coumadin he does not have to do anything at that point. Respondent testified that was correct – the patient would be in good shape and he has had situations where he has had to go in and do surgery and thankfully they did not bleed.

11. The Board asked Respondent if he was saying the nursing staff gave RB six units of FFP in two hours. Respondent testified he was. Respondent testified usually the nursing staff is very late and he was surprised they did it so quickly because it usually takes forty-five minutes to get just one unit from the bank and get it in the IV tubing. Respondent testified in RB's case they unfortunately had already gotten all six units after they got the order from Dr. A and they started giving RB the six units wide open without even checking the PT. The Board again asked Respondent if Dr. A ordered the six units of FFP. Respondent testified she had. The Board asked Respondent if it was difficult at the hospital to access the actual CT scan in addition to the report, whether or not he could have pulled it up. Respondent testified he could access it and he did, two hours later. The Board noted two hours in RB's situation was very critical. Respondent testified he would not have given RB the two units of FFP in the first place. The Board noted that Respondent would have been able to stop it had he looked at the CT scan earlier. Respondent agreed and testified he wished he had.

12. The Board directed Respondent to Dr. A's response to the Board where she describes the events differently and claims the nurse advised her that Respondent requested she order FFP to reverse the PT and it was to be done as expeditiously as possible. Dr. A claimed she immediately returned to evaluate RB given the plan of emergent neurosurgery and ordered the six units of FFP to be infused as quickly as possible so RB could be taken to surgery per Respondent's plan. Dr. A also claimed Respondent ordered the FFP infused "STAT." The Board noted there was a disconnect between Respondent's interpretation of what happened and Dr. A's interpretation. The Board noted the inference was that Respondent stood at RB's bedside and ordered six units of FFP STAT. Respondent testified the order did not come from him, it came from Dr. A. Respondent testified he was with RB at 12:00 and came back two hours later, but by that time unfortunately she had gotten the six units of FFP. Respondent testified when he says he wants the PT corrected he says he wants it to start as soon as possible or STAT, but that means giving one unit every three to four hours and then checking the PT after two units. Respondent testified he never imagined someone would give an eighty-eight year-old patient with coronary artery disease six units of FFP right away. Respondent testified he would never give wide open fluids to an eighty-eight year-old patient.

13. The Board noted Dr. A's response claimed that as a result of Respondent's order at the bedside to the nurse to infuse the FFP ordered by Dr. A "STAT" the nurse began infusing the FFP as quickly as possible. The Board noted it also would indicate RB was taken up to the operating room. Respondent testified he only saw RB in the preop area of the ICU. Respondent testified he just wanted the FFP to be *started* STAT not given six units wide open without any Lasix in between. The Board asked Respondent if he ever talked directly to Dr. A or were they seeing RB at different times and making inferences about what the other wanted. Respondent testified they were seeing RB at different times.

14. The Board noted its impression from reviewing the record was that RB made it to the operating room and the portion that is disturbing is where the record says Respondent wanted RB in the operating room by 1500 and Respondent was in another patient's surgery when, during the course of infusing the FFP, the nurse noted RB began to experience congestive heart failure. Respondent testified he wanted RB in the operating room at 1500 if her PT was corrected. The Board directed Respondent to the order sheet on page 38 of the medical records that says "Transferred to ICU" and asked Respondent to read the next couple of words. Respondent read "repeat CB, CMC, PT PTT transfer to ICU for close monitoring." The Board noted it then said "six units FFP transfused. Vitamin K given. Call results to [Respondent]." The Board noted from this entry it looked as if Respondent gave these orders. Respondent testified these are not his orders – it was definitely not his handwriting. The Board noted it said to call the results to Respondent and he must have asked them to do that. Respondent testified he did not, it could be just that anytime a physician wants to notify another physician of results they say "oh, okay, you can call the results to" the other doctor. Respondent testified these were definitely not his orders because Dr. A gave the order for the units of FFP. Respondent was asked to explain the nursing note suggesting he ordered the FFP. Respondent testified his intent was that they start the FFP as soon as possible, but he would not have given her six units wide open. Respondent testified the order was given by Dr. A as was the order to transfer. The Board noted it had to assume from everything it had reviewed that RB made her way to the operating room and patients do not usually get to the operating room unless the surgeon schedules the case. Respondent testified RB was seen by the anesthesiologist in the ICU to assess her because it is better for the patient not to leave ICU.

15. The Board noted Respondent misunderstood its point that a patient does not get to the operating room unless the surgeon has scheduled the case at a certain time and Respondent scheduled the case without seeing the CT scan and with a patient who was not in dire

circumstances. Respondent testified RB's PT was also elevated and he wanted to check the CT scan, which he did two hours later and he told RB she may need the surgery if she deteriorated just from the fact she was on Coumadin. Respondent testified he would have liked, and ideally in this situation, the FFP would have been started and given every three hours and then check the PT and, if it normalized, of course he could think about taking her to surgery. Respondent testified when he found out the CT scan was normal he cancelled the whole surgery, but it was two hours later.

16. The Board summarized its understanding that Respondent saw RB, was told by someone there was an epidural hematoma on CT scan, which he did not review, he scheduled RB for surgery pending correction of the INR and PT with FFP, expecting the coagulation deficiency would be corrected by two units, not six, but Respondent was then doing another surgery. Respondent testified he did not recall being in another surgery. The Board noted Dr. A's response said the nurse testified in her deposition that she contacted the anesthesiologist who had seen RB to tell him RB was getting into trouble, and when she spoke with him he was in surgery with Respondent. Respondent testified he did not recall being in another surgery with the anesthesiologist. The Board asked Respondent if it was correct that he made up his mind to do the surgery prior to reviewing the CT scan because of RB's clinical symptoms and he asked Dr. A to correct the bleeding time by giving FFP, but if he had seen the CT scan he probably would not have asked Dr. A to give FFP. Respondent testified this was absolutely correct. The Board asked Respondent if he then felt at fault for asking for the FFP because he was already planning for surgery. Respondent testified he did, but he does that all the time and RB did have some elevated intracranial pressure so that was the other thing to start reversing the Coumadin slowly and, he thinks if it had been done cautiously, RB would not have had the fluid overload she got after Dr. A gave her wide open FFP without even checking with Respondent.

17. The Board asked Respondent if he thought the PT could be corrected within the short period of time from when he saw RB and the time he scheduled the surgery. Respondent testified it has happened in the past and he has had other situations were he needed to give six units over three days. The Board again asked Respondent if he thought the thinning would be corrected in two or three hours. Respondent testified he thinks the only safe way would be to repeat the PT after giving one or two units with Lasix in between; sometimes it corrects after just two units because of the liver and it depends on what the condition is, but other times it does not correct and he will not take the patient to surgery unless she is herniating or threatening to die in front of him. Respondent testified unless RB's PT corrected he would have never taken her to surgery.

18. The Board directed Respondent to the hospital chart where it is documented he saw RB at 12:35, which corresponds to Respondent's recollection of time, and there is a nurse's note on page 198 that is difficult to read but says "[Respondent] at bedside increase Vitamin K. Wants FFP transfused with IVP piggyback. FFP infused ASAP." "To be taken to OR at 1500." Respondent testified this was his interpretation as well. The Board noted it sounded like Respondent told the nurses to do the FFP STAT so RB could be taken to the OR at 1500.

19. The Board asked Respondent if he operated on one-hundred percent of the epidural hematomas he sees. Respondent testified he did not. The Board asked Respondent how he decided whether he was going to operate or whether he was going to observe the patient neurologically and not operate. Respondent testified normally he goes by whether the patient has any signs of intracranial pressure and he also examines them to find out if they have any type of neurological deficit. The Board noted Respondent really had to look at the CT scan before he knew whether it was operative or not. Respondent agreed. The Board noted in other words Respondent had to look at the CT scan to decide whether or not the hematoma is large enough

for the patient to be taken to surgery now or whether or not he is going to observe the patient. Respondent agreed.

20. The Board noted there were a lot of problems in RB's case and that it had to be careful not to over-interpret Dr. A's response in her in own defense. The Board noted one major problem in RB's case was the misdiagnosis by Respondent.

21. The standard of care requires the neurosurgeon to see the patient and evaluate the patient by doing a history and physical and neurological examination and to review critical imaging studies before embarking on a surgical approach.

22. Respondent deviated from the standard of care because he failed to properly evaluate RB through critical imaging studies prior to embarking on a surgical approach.

23. RB was harmed because as a result of Respondent's decision to perform a surgical procedure she was given a very fast rate of FFP infusion that caused congestive heart failure with cardiac and pulmonary complications and overload.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice which is or might be harmful or dangerous to the health of the patient or the public").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Letter of Reprimand for failure to properly evaluate the patient through critical imaging studies prior to embarking on a surgical procedure.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 6th day of April, 2006.

ARIZONA MEDICAL BOARD 1913 STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

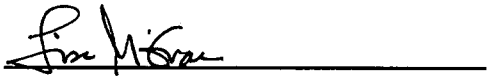
ORIGINAL of the foregoing filed this 7th day of April, 2006 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Mail this
7th day of April, 2006, to:

Paul Giancola
Snell & Wilmer, LLP
One Arizona Center
400 East Van Buren
Phoenix, Arizona 85004

Mazen H. Khayata, M.D.
Address of Record



BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MAZEN H. KHAYATA, M.D.** Holder of License No. **20382** For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-04-1504A** **ORDER DENYING REHEARING OR REVIEW**

At its public meeting on June 8, 2006 the Arizona Medical Board ("Board") considered a Petition for Rehearing or Review filed by Mazen H. Khayata, M.D. ("Respondent"). Respondent requested the Board conduct a rehearing regarding its April 7, 2006 Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand. The Board voted to deny the Respondent's Petition for Rehearing or Review upon due consideration of the facts and law applicable to this matter.

ORDER

IT IS HEREBY ORDERED that:

Respondent's Petition for Rehearing or Review is denied. The Board's April 7, 2006 Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand is effective and constitutes the Board's final administrative order.

RIGHT TO APPEAL TO SUPERIOR COURT

Respondent is hereby notified that he has exhausted his administrative remedies. Respondent is advised that an appeal to Superior Court in Maricopa County may be taken from this decision pursuant to title 12, chapter 7, article 6.

DATED this 13th day of June, 2006.

ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13th day of June, 2006 with:

The Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 13th day of June, 2006, to:

Paul J. Giancola, Esq.
Snell & Wilmer
400 E. Van Buren
Phoenix, Arizona 85004

Mazen H. Khayata, M.D.
Address of Record

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